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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01936 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01917

1. PLACE OF DEATH
a. COUNTY: Harford County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle A. — Last ALEXANDER

4. DATE OF DEATH: Month February — Day 5, — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/7/30

9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: General Trucking

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Auburn Alexander

14. MOTHER'S MAIDEN NAME: Beatrice Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-24-5160

17. INFORMANT — Address: Mrs. Robert A. Alexander, North East, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of head and brain
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot in head

20c. TIME OF INJURY — Hour e.m.: 2:55 — Month, Day, Year: Feb. 5, 1962

20d. INJURY OCCURRED — While at work ☐ — Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Motel

20f. (City or town): Edgewood, Maryland — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Howard G. Shaub M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): HOWARD G. SHAUB, M. D.

Address (Street, city, town, or county):

DATE SIGNED: 2/6/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-8-62

22c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.

22d. LOCATION (City, town, or country) (State): North East, Maryland

23. FUNERAL DIRECTOR: Joseph R Grant — Joseph R. Grant

ADDRESS: North East, Maryland.

24a. REC'D BY REGISTRAR — DATE: FEB 8 - '62

24b. REGISTRAR'S SIGNATURE: Evelyn L. Keene

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01937 **CERTIFICATE OF DEATH** 01918

**1. PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: Dead on Arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US Army Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Abingdon
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First CONWAY — Middle — Last BORUFF

**4. DATE OF DEATH**: Month February — Day 13 — Year 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Cau

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: August 16, 1899

**9. AGE** (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Officer

**10b. KIND OF BUSINESS OR INDUSTRY**: US Army

**11. BIRTHPLACE** (County & State, or foreign country): Claybourn ~~Nashville~~, Tenn

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Sampson Boruff

**14. MOTHER'S MAIDEN NAME**: Elizabeth Butcher

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): Yes — WW1 & WW 2

**16. SOCIAL SECURITY NO.**: 292-28-0183

**17. INFORMANT** Address: Mrs. Ruth Boruff (Wife) Abingdon, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion, Massive — INTERVAL BETWEEN ONSET AND DEATH: Unk
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at 8:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: Garland White Capt MC M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: February 13, 1962

22c. PHYSICIAN'S NAME (Type): GARIAND WHITE, Captain, MC US Army — 22d. ADDRESS: US Army Hospital, Aberdeen Proving Ground, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 23b. DATE THEREOF: 2/15/1962 — 23c. NAME OF CEMETERY OR CREMATORY: Reeb Funeral Home — 23d. LOCATION (City, town or county) (State): Sylvania, Lucas Co., Ohio

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Mc Comas & Son — ADDRESS: Abingdon Maryland. — 25a. REC'D BY REGISTRAR DATE: FEB 19 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01919

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Forest Hill
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Putnam Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Forest Hill
d. STREET ADDRESS: Putnam Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Eugene Middle Thomas Last Buckingham

4. DATE OF DEATH: Month February Day 13 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 19, 1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired): Retired Purchasing Agent

10b. KIND OF BUSINESS OR INDUSTRY: Merchants & Miners

11. BIRTHPLACE (State or foreign country): Howard County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Buckingham ?

14. MOTHER'S MAIDEN NAME: Standiford ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No ---

16. SOCIAL SECURITY NO.: 160-03-8009

17. INFORMANT: Mrs. Louis O. Ford
Address: 1827 E. Joppa Road Balto. 34, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Arteriosclerotic C V disease — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer - MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Bel Air, Md.

DATE SIGNED: 2-13-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/19/1962

22c. NAME OF CEMETERY OR CREMATORY: West Laurel

22d. LOCATION (City, town, or country) (State): Philadelphia Pa.

23. FUNERAL DIRECTOR: Charles E. Kurtz
ADDRESS: Jarrettsville, Md.

24a. REC'D BY REGISTRAR
DATE FEB 15 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom portion may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G308 3/2/62 iwk

01939

01920

# CERTIFICATE OF DEATH

Reg. Dist. No.....

**1. PLACE OF DEATH**

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace Rural

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Md COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace

STREET ADDRESS (If rural give location) Rural

**3. NAME OF DECEASED** (Type or Print) (First) Charles (Middle) E (Last) Chapman

**4. DATE OF DEATH** (Month) Feb (Day) 20 (Year) 1962

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED,~~ (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | March 26 1880 | 81 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Carpenter | | Harford Co Md | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Elijah Chapman | Catherine Chapman |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | | 212-18-5246 | Mrs. Charles Chapman Havre de Grace Md Rural |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 331 IMMEDIATE CAUSE (A) | Uremia | 5 days |
| ANTECEDENT CAUSE(S) DUE TO (B) | Generalized Arteriosclerosis | 5 yr |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | |

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Vascular Accident — 6 mos

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Dey) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from May 9, 1950, to Feb 20, 1962, that I last saw the deceased alive on Feb 21, 1962, and that death occurred at .....M, from the causes and on the date stated above.

**SIGNATURE** Dudley Phillips MD M.D. **ADDRESS** (Street, city, town, state) Darlington Md **DATE SIGNED** 2/22/62

| 23. BURIAL, ~~CREMATION, REMOVAL (SPECIFY)~~ | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Feb 23, 1962 | Rock Run | Harford Co, Md |

| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| DATE FEB 27 '62 | [signature] | H S Bailey | Darlington Md |

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01940

## CERTIFICATE OF DEATH

01921

1. **PLACE OF DEATH**
   a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residance before admission)
   a. STATE: MARYLAND — b. COUNTY: HARFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X EDGEWOOD
   d. STREET ADDRESS: 40 STARR ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First — Middle — Last: COULTER

4. DATE OF DEATH: Month: FEB — Day: 16 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 16, 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): HARFORD. Co. MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DONALD COULTER

14. MOTHER'S MAIDEN NAME: HELEN B. McROBERTS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congenital Heart disease (or chambered heart)
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 754.5

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/14, 196~ to 2/16, 196~ that (I) (we) last saw the deceased alive on 2/14 19 6~, and that death occured at 1:05 PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/16/62

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): 2/16/62

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Hospital

23d. LOCATION (City, town or county) (State): Havre de Grace, md.

24 FUNERAL DIRECTOR'S SIGNATURE: Harry R Talley

ADDRESS: 507 S. Union Ave Havre de Grace, md

25a. REC'D BY REGISTRAR DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kress

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

207326122

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01922

01941

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If inst tution Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS:
e. IS RES DENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Alfred — Middle: W. — Last: Cullum

4. DATE OF DEATH: Month: Feb. — Day: 26 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 10, 1901

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY: Stone

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Archer Cullum

14. MOTHER'S MAIDEN NAME: Lavania Bull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-10-8892

17. INFORMANT: Address: Mrs. Grace Cullum, Street, Md.

18. CAUSE OF DEATH [Enter only one cause per l ne for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLY NG ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p m — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 8 1947 to Feb 26, 1962 that (I) (we) last saw the deceased alive on Feb 25 1962 and that death occured at 8 A.M, from the causes and on the date stated above

22a. SIGNATURE: Dudley Phillips M.D.

22b. DATE SIGNED: 2/26/62

22c. PHYSICIAN'S NAME (Type): Dudley Phillips

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Darlington Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-2-62

23c. NAME OF CEMETERY OR CREMATORY: Ascension

23d. LOCATION (City, town or county): Scarboro, (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Harkins

ADDRESS: Delta, Pa.

25a. REC'D BY REGISTRAR DATE MAR 1 '62

25b. REGISTRAR'S SIGNATURE: Alva L. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A1S (4)
1SM 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01942 Reg. Dist. No. 01923

1. PLACE OF DEATH
a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: 61 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cherry Hill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Street
d. STREET ADDRESS: Cherry Hill Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Elmo Middle Dick Last
4. DATE OF DEATH: Month February Day 24 Year 1962

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: August 7, 1900
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Dairy
11. BIRTHPLACE (State or foreign country): Street, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Dick
14. MOTHER'S MAIDEN NAME: Ruth Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: -----
17. INFORMANT: Willard Dick Address: Cardiff, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriocsclertic CV Disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-24-62, 19____, to 2-24-62, 19____, that I last saw the deceased alive on 2-24-62, 19____, and that death occurred at 3 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer / M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 2-24-62

PHYSICIAN'S NAME (Type): Gerald C. Palmer M.D. Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 28, 1962
22c. NAME OF CEMETERY OR CREMATORY: Highland
22d. LOCATION (City, town, or county) (State): Street, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Hudkins ADDRESS: Delta, Pa.
24a. REC'D BY REGISTRAR DATE: MAR 1 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01943 — 01924

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD. (MARYLAND)
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CARDIFF
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GERALD Middle V. Last EATON

4. DATE OF DEATH: Month FEBRUARY Day 24 Year 1962

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR. 25, 1913
9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MILLWORKER
10b. KIND OF BUSINESS OR INDUSTRY: SLATE
11. BIRTHPLACE (County & State, or foreign country): STEWARTSTOWN, PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLIFTON EATON
14. MOTHER'S MAIDEN NAME: MARY BURKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO: 215-07-9107
17. INFORMANT Address: MRS. ALICE EATON, CARDIFF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY Thrombosis.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb ..... 19 50, to Feb 24, 1962 that (I) (we) last saw the deceased alive on Feb 23 19 62, and that death occured at 7:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips MD M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-24-62
22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD
22d. ADDRESS: DARLINGTON MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-27-62
23c. NAME OF CEMETERY OR CREMATORY: ST. MARYS
23d. LOCATION (City, town or county) (State): PYLESVILLE, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Hardina
ADDRESS: DELTA, PA.

25a. REC'D BY REGISTRAR DATE MAR 1 '62
25b. REGISTRAR'S SIGNATURE: Wallace E. Thomas

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01944 — 01925

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 23 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US Army Hospital Aberdeen PG Md

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Aberdeen
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HILTON — Middle CLAY — Last FARMER

4. DATE OF DEATH: Month Feb — Day 27 — Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 29 Aug 1909

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Ash, North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James P Farmer

14. MOTHER'S MAIDEN NAME: Myra E Sapp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 186-14-7466

17. INFORMANT: Address: Mrs Elizabeth Farmer (Wife) same as 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Increased intracerebral pressure — INTERVAL BETWEEN ONSET AND DEATH: 23 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): producing respiratory arrest and cardic arrest
DUE TO (c): injury (missile) to brain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Small missile penetrated skull (nail from power tool)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. 10:30 p.m — Feb 26 19 62

20d. INJURY OCCURRED While at work [X] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Work

20f. (City or town) (County) (State): Aberdeen PG Harford Md

21. **I certify** that (I) (this hospital) attended the deceased from Feb 26 ..... 19 62 to Feb 27 ..... 19 62, that (I) (we) last saw the deceased alive on Feb 27 ..... 19 62, and that death occured at 10A M, from the causes and on the date stated above.

22a. SIGNATURE: Samuel J. Abrams M D

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 27 Feb 62

22c. PHYSICIAN'S NAME (Type): SAMUEL J ABRAMS

22d ADDRESS: US Army Hospital Aberdeen PG Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/2/1962

23c. NAME OF CEMETERY OR CREMATORY: Highland Presbyterian

23d. LOCATION (City, town or county) (State): Street, Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE: Tarring Funeral Home — ADDRESS: Aberdeen Md

25a. REC'D BY REGISTRAR DATE: 5 '62

25b. REGISTRAR'S SIGNATURE

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01945 — **CERTIFICATE OF DEATH** — 01926

Items 8 & 9 Film G307 2/19/62 iwk

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAURE de GRACE
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAURE de GRACE
d. STREET ADDRESS: 169 Bloomsbury
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: S Last: GROAK (GROAK) Sr.

4. DATE OF DEATH: Month: FEBRUARY Day: 10 Year: 1962

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 3, 1893
9. AGE (Last birthday) yrs.: 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Ret. Engr. Foreman C.P. Elevator
11. BIRTHPLACE (County & State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles GROAK (GROAK)
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Helen L. Groak Address: 169 Bloomsbury Ave. Haure de Grace Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 6-7 weeks
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 7th 1962 to Feb 10th 1962 that (I) (~~we~~) last saw the deceased alive on Feb 10th 1962 and that death occured at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb. 10th, 62
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Haure de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/13/62
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill
23d. LOCATION (City, town or county) (State): Haure de Grace Md

24 FUNERAL DIRECTOR'S SIGNATURE: Thomas Dr, Haure de Grace Md.
ADDRESS

25a. REC'D BY REGISTRAR DATE: FEB 13 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Friese

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01946

## CERTIFICATE OF DEATH

01927

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

**1. PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN MARYLAND: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 441 Moore's Mill Road

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 441 Moore's Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: William; Middle: Brierly; Last: Gross

**4. DATE OF DEATH**: Month: FEB; Day: 15; Year: 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Jan. 6, 1926

**9. AGE** (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerical

**10b. KIND OF BUSINESS OR INDUSTRY**: Utility Company

**11. BIRTHPLACE** (County & State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: Benton H. Gross, Sr.

**14. MOTHER'S MAIDEN NAME**: Lucille Wright

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): Yes W.W. #2

**16. SOCIAL SECURITY NO**: 213-20-6792

**17. INFORMANT**: (Wife) Address: 441 Moores Mill Mrs. Kathryn M. Gross Bel Air, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | CARDIO-RESP. FAILURE | 3 DAYS |
| 181.7 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) | METASTATIC CARCINOMA | 6 MONTHS |
| DUE TO (c) | CARCINOMA OF URACHUS | 2½ YRS |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURED** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from ..... 19 43 to 15 FEB 19 62 that (I) (we) last saw the deceased alive on 15 FEB 1962, and that death occured at 7:30 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: H. P. Sidwell M.D., M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 15 Feb 62

**22c. PHYSICIAN'S NAME** (Type): H.P. SIDWELL M.D.

**22d. ADDRESS**: 401 FRANKLIN ST. BEL AIR. MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 2/17/1962

**23c. NAME OF CEMETERY OR CREMATORY**: Bel Air Memorial Gardens

**23d. LOCATION** (City, town or county) (State): Bel Air, Harf. Co., Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Joseph W. Foster

**ADDRESS**: W. Broadway & Williams St. Bel Air, Maryland

Joseph W. Foster

**25a. RECD BY REGISTRAR DATE**: FEB 20 '62

**25b. REGISTRAR'S SIGNATURE**: Clint L. Thoma

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01928

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b: MARYLAND 9 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa
d. STREET ADDRESS: Route # 1. Box 32
e. IS RESIDENCE ON A FARM? YES [ ] NO [ ]

3. NAME OF DECEASED (Type or print): First: Irene (Maude) Last: Bagley Harbaugh
4. DATE OF DEATH: Month: February Day: 27 Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 25, 1884
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Tenant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.,
13. FATHER'S NAME: Charles Bagley
14. MOTHER'S MAIDEN NAME: Ella Mc Cauley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 220-30-6731
17. INFORMANT: Frank C. Harbaugh Address: Joppa Md.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C V disease
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from. Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M D
NAME (Type): Gerald C Palmer
CHIEF MEDICAL EXAMINER [ ] Bel Air, Md.
ASSISTANT MED.CAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city town, or county)
DATE SIGNED: 2-25-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 3, 1962
22c. NAME OF CEMETERY OR CREMATORY: Union Chapel ADDRESS
22d. LOCATION (City, town, or country) (State): Joppa, Harford, Maryland

23. FUNERAL DIRECTOR: Howard K. Mc Comas & Son Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: MAR 5 '62
24b. REGISTRAR'S SIGNATURE: Clothier L. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

01948 — 01929

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
c. LENGTH OF STAY IN 1b: 46 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Grior Nursery Road

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write R and give nearest town): Forest Hill
d. STREET ADDRESS: Grier Nursery Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Hyle — Last: Harward

4. DATE OF DEATH: Month: February — Day: 15, — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1905

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Automotive Supply

11. BIRTHPLACE (City & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Walter H. Harward

14. MOTHER'S MAIDEN NAME: Mary Kelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO: 215-03-3253

17. INFORMANT: (Sister) Mrs. David Preston — Address: Grier Nurs. Rd. Forest Hill, Md/

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: approx 10hs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary thrombosis
DUE TO (c): atherosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): moderate pulmonary emphysema & fibrosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): N/A

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/27, 1960 to 2/15, 1962 that (I) (we) last saw the deceased alive on 2/15, 1962, and that death occured at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE: Warren R. Lesch M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 2/16/62

22c. PHYSICIAN'S NAME (Type): Warren R. Lesch, M.D. — 22d. ADDRESS: 202 S. Main Street, Bel Air, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/17/62 — 23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Cem. — 23d LOCATION (City, town or county) (State): Hickory, Harf. Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland

Joseph W. Foster

25a. REC'D BY REGISTRAR DATE: FEB 20 '62 — 25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01949 — Items 8, 9, 10a & 10b, Film G-508 3/1/62 cac. — 01950

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAVRE de GRACE
   c. LENGTH OF STAY IN 1b: 7 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: HARFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STREET
   d. STREET ADDRESS: Davis Corner Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: Ruth — Last: HOLBROOK

4. DATE OF DEATH: Month: Feb. — Day: 26 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 11 1934 1935

9. AGE (In years last birthday): 27 26 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Electrical

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILBUR HARRIS

14. MOTHER'S MAIDEN NAME: MARGARET RITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-34-6729

17. INFORMANT (Husband): Avery Dwight Holbrook — Address: RFD #2, Box 24 Street, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Anemia and Acidosis | 36hr |
| DUE TO (b) | Transfusion Reaction and a Severe | 36hr |
| DUE TO (c) | Chronic Pyelonephritis | 5yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Severe Secondary Anemia from Pyelonephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 19 57 to Feb 26, 1962 that (I) (we) last saw the deceased alive on Feb 25 19 62 and that death occured at 6:11 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips MD — M.D.

22b. DATE SIGNED: 2/24/62

22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: DARLINGTON, Md

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 28, 1962

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City, town or county) (State): Bel Air, Harford Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway and Williams St Bel Air, Maryland

Joseph W. Foster

25a. REC'D BY REGISTRAR DATE: FEB 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

01950 — 01931

1 — M — I — X

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**1. PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 438 Edmund Street

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 438 Edmund Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Sadie; Middle: Elizabeth; Last: Hubard

**4. DATE OF DEATH**: Month: 2; Day: 4; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12/8/1903

**9. AGE** (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Home

**11. BIRTHPLACE** (County & State, or foreign country): New Jersey

**12. CITIZEN OF WHAT COUNTRY?**: USA.

**13. FATHER'S NAME**: Joshua Hardy

**14. MOTHER'S MAIDEN NAME**: Gertrude Moulton md.

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO**: 213-26-3634

**17. INFORMANT**: Gloria Weddle — Address: 438 Edmund St. Aberdeen

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — 420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertensive Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**MEDICAL CERTIFICATION**

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/12 1960, to 2/3 1962, that (I) (we) last saw the deceased alive on Feb. 3, 1962, and that death occured at 7:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/5/62
22c. PHYSICIAN'S NAME (Type): George T. Stansbury
22d. ADDRESS: 529 Revolution St Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/8/1962
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
23d. LOCATION (City, town or county) (State): Aberdeen, Rural Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Aberdeen, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 7 '62
25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

1

FOR STATE HEALTH DEPT.

M

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01951 01932

1. **PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood R.D.,
c. LENGTH OF STAY IN 1b: 2 yrs
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jones Farm

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Edgewood R.D. Box 13
d. STREET ADDRESS: Jones Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Reed Middle: Hudson Last:

4. **DATE OF DEATH**: Month: February Day: 10 Year: 1962

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Nov. 18, 1913

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Darlington, S.C.,

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): yes WW II

16. SOCIAL SECURITY NO.: 248-03-1982

17. INFORMANT: Margaret Hudson Address: Edgewood R.D., Maryland

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asteriosclerotic C V disease
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D

EXAMINER'S NAME (Type): Gerald C Palmer-MD

CHIEF MEDICAL EXAMINER [ ] Bel Air, Md.
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

DATE SIGNED: 2-10-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 13, 1962

22c. NAME OF CEMETERY OR CREMATORY: John Wesley
ADDRESS: Abingdon, Md.,

22d. LOCATION (City, town, or county) (State): Abingdon, Harford, Maryland

23. FUNERAL DIRECTOR: Howard K. Mc Comas & Son

24a. REC'D BY REGISTRAR: DATE FEB 14 '62

24b. REGISTRAR'S SIGNATURE: Esther L. Kuna

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01952

## CERTIFICATE OF DEATH

01333

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bel Air
c. LENGTH OF STAY IN 1b 58 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Toll Gate Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bel Air
d. STREET ADDRESS Toll Gate Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Elizabeth Middle: May Last: Joesting
4. DATE OF DEATH Month: February Day: 5, Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 8, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: S. A. Foutz
14. MOTHER'S MAIDEN NAME: Miriam Cook
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT (Son): John F. Joesting
Address: R.F.D. #1 Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C V disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 422.1
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-17 19 37 to 2-5 19 62, that (I) (we) last saw the deceased alive on 2-4 1962, and that death occured at 1 AM, from the causes and on the date stated above.

22a. SIGNATURE Gerald C Palmer M.D
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED 2-5-62
22c. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M. D.
22d. ADDRESS S. Main Street, Bel Air, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 7, 1962
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City, town or county) (State): Bel Air, Harf. Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster
ADDRESS: W. Broadway & Williams Bel Air, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

Joseph W. Foster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01953

## CERTIFICATE OF DEATH

Reg. Dist. No. 01934

1 PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Forest Hill
c. LENGTH OF STAY IN 1b: 87 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Forest Hill
d. STREET ADDRESS Chestnut Hill
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First SAVANNAH Middle Last JOHNSON

4. DATE OF DEATH: Month Feb. Day 19 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Feb. 4, 1875
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Chestnut Hill, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Ward.
14. MOTHER'S MAIDEN NAME: Virginia J. McLaughlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
INFORMANT: James M. Johnson — Address: Forest Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARDIO-RESP. FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

3 34-X

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ADVANCED ARTERIOSCLEROSIS — 6 MO
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CONGESTIVE HEART FAILURE + STROKE 3YRS AGO

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 FEB, 1962, to 18 FEB, 1962, that I last saw the deceased alive on 18 FEB, 1962, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H P Sidwell M.D. — M.D.
ADDRESS (Street, city or town, state): 401 Franklin St
DATE SIGNED: 1/24/62
PHYSICIAN'S NAME (Type): H. P. SIDWELL — Bel Air, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/21/62
22c. NAME OF CEMETERY OR CREMATORY: Deer Creek
22d. LOCATION (City, town, or county) (State): Chestnut Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz — ADDRESS: Jarrettsville Md
24a. REC'D BY REGISTRAR — DATE: FEB 23 '62
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01954

## CERTIFICATE OF DEATH

01935
Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

| | |
|---|---|
| 1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: HARFORD |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - BEL AIR | c. LENGTH OF STAY IN 1b: 5 years |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---- | d. STREET ADDRESS: RD #2, Box 216 |
| e. IS RESIDENCE ON A FARM? YES ☒ NO ☐ | |

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| JOHN | HENRY | KLEIN | FEBRUARY | 12 | 1962 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min |
|---|---|---|---|---|---|---|
| Male | White | | Sept. 3, 1884 | 77 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Mason, Stone | Masonary | Balto. Co. Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Klein | Anna Zinkhan |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | Address |
|---|---|---|---|
| No. --- | 21-03-4167 | Mrs. Kenneth Davis | Box 216 RD #2 Bel Air, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Myocardial infarction | 2 hours |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) | Coronary occlusion | 2 hours |
| DUE TO (c) | Arteriosclerotic cardiovascular disease | 10 or more years |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that I attended the deceased from April 15, 1954, to February 12 1962, that I last saw the deceased alive on February 12, 1962, and that death occurred at 8:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul S. Stonesifer Jr. M.D. — ADDRESS (Street, city or town, state): 115 Fulford Ave., Bel Air, Md. — DATE SIGNED: 2/12/62

PHYSICIAN'S NAME (Type): PAUL S. STONESIFER JR., M. D.

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 2/15/1962 | Jarrettsville | Jarrettsville, Maryland |

| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR DATE | 24b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles E. Kurtz | Jarrettsville, Md. | FEB 14 '62 | Corinne L. Krauss |

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the register within **72 hours** after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01955

# CERTIFICATE OF DEATH

01936

Reg. Dist. No. .....

**1. PLACE OF DEATH**

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rocks

LENGTH OF STAY (In this place): 50 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rocks

STREET ADDRESS (If rural give location): Knopp Road

**3. NAME OF DECEASED** (Type or Print): (First) HENRIETTA (Middle) REYNOLDS (Last) KNOPP

**4. DATE OF DEATH** (Month) FEB. (Day) 20 (Year) 1962

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | July 10, 1882 | 79 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Chrone Hill, Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harman Ira Reynolds | Mary Truman |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | --- | 218-14-5604 | Harry C. Knopp Rocks, Md. |

**18. MEDICAL CERTIFICATION**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — IMMEDIATE CAUSE (A) | Tbc. Meningitis | 2½ mos. |
| ANTECEDENT CAUSE(S) DUE TO (B) | Pulmonary Tbc. | Tbc. 1 yr. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. ~~DUE TO~~ (C) | Diabetes Mellitus | 12 yrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 8/20, 1950, to 2/20, 1962, that I last saw the deceased alive on 2/15, 1962, and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE Robt Barth M.D. ADDRESS (Street, city, town, state) Forest Hill Md. DATE SIGNED 2/20/62

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 2/22/1962 | William Watters | Cooptown, Maryland |

| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| FEB 23 '62 | [illegible] | Charles E. Kurtz | Jarrettsville, Md. |

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01956 **CERTIFICATE OF DEATH** 01937

Item 13 Film G508 3/2/62 iwk

1. **PLACE OF DEATH**
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL

2. **USUAL RESIDENCE** (Where deceased lived, If Inst tution, Residence before admiss on)
a. STATE: Maryland b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS: #1 Horseshoe Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First Elizabeth Middle Scott Last MACE

4. **DATE OF DEATH**: Month FEBRUARY Day 26 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 10, 1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give k nd of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Wyoming

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emory Allen Scott

14. MOTHER'S MAIDEN NAME: Amy REESE

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16 SOCIAL SECURITY NO: 089-03-8986

17. INFORMANT Address: W.E Mace Rising Sun, Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a) (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Rheumatic myocarditis — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIF CANT COND TIONS CONTRIBUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of Item 18.]

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6 ..., 19 61 to 2/27 ..., 1962, that (I) (we) last saw the deceased alive on 2/26 ..., 1962, and that death occured at 11:35 P.M., from the causes and on the date stated above.

22a SIGNATURE: Neil Taylor M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/27/62

22c. PHYSICIAN'S NAME (Type): Neil Taylor M.D.

22d. ADDRESS: Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/2/1962

23c. NAME OF CEMETERY OR CREMATORY: West Nottingham

23d. LOCATION (City, town or county) (State): Colora, Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ralph M Reed, Rising Sun, Md.

25a. REC'D BY REGISTRAR DATE FEB 28 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 41
15M 7 61

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 5 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01938

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benson
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benson
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Preston — Middle: Lee — Last: Magness, Sr.

4. DATE OF DEATH: Month: February — Day: 23 — Year: 19 62

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 15, 1903

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Auto

11. BIRTHPLACE (State or foreign country): Harford County, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Ramsay Lee Magness

14. MOTHER'S MAIDEN NAME: Carrie Stoffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-03-2975

17. INFORMANT: Mrs. Carrie Magness — Address: Benson, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

Address (Street, city, town, or county): Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: February 26, 1962

22c. NAME OF CEMETERY OR CREMATORY: Mountain Christian

22d. LOCATION (City, town, or country) (State): Joppa, Maryland

23. FUNERAL DIRECTOR: W. H. ARCHER — ADDRESS: Benson, Md.

24a. REC'D BY REGISTRAR DATE: MAR 1 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

W. H. ARCHER Benson, Md.

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01939

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belcamp
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belcamp
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Norman Middle D. Last Massey

4. DATE OF DEATH Month February Day 5 Year 19 62

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb 15, 1903

9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN MASSEY

14. MOTHER'S MAIDEN NAME INDIANA SATTERFIELD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 218-10-4549

17. INFORMANT Address MRS. ANNA MASSEY = BELCAMP MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b) — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.

EXAMINER'S NAME (Type) Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county) Belcamp Md.

DATE SIGNED 2-5-62

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF FEB. 7

22c. NAME OF CEMETERY OR CREMATORY CHURCH HILL

22d. LOCATION (City, town, or country) CHURCH HILL (State) MD.

23. FUNERAL DIRECTOR Edgar L. Janes ADDRESS Church Hill, Md.

24a. REC'D BY REGISTRAR DATE FEB 13 '62

24b. REGISTRAR'S SIGNATURE Wm. E. Harris

VS. A15ME SM 9 60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

C1959 — Reg. Dist. No. 01940

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: 10 yrs.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewood
d. STREET ADDRESS: 17 Mc Cann
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: B. — Last: Mc Daniel

4. DATE OF DEATH: Month: Feb. — Day: 14 — Year: 19 62

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov.16,1887

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Rockwood, Tenn.,

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Joseph Mc Daniel

14. MOTHER'S MAIDEN NAME: Mattie Mc Gee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 400-09-3321

17. INFORMANT: Everett Mc Daniel — Address: Corbin, Ky.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Anemia, Pulmonary Hemorrhage

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 9, 1960, to Feb 14, 1962, that I last saw the deceased alive on Feb. 7, 1962, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Louis Kahan, M.D. — ADDRESS (Street, city or town, state): Edgewood Maryland — DATE SIGNED: Feb. 14, 1962

PHYSICIAN'S NAME (Type): E. Louis Kahan — Edgewood Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb.17,1962 — 22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens — 22d. LOCATION (City, town, or county) (State): Bel Air,Harford, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Mc Comas & Son — ADDRESS: Abingdon,Md.,

24a. REC'D BY REGISTRAR DATE: FEB 20 '62 — 24b. REGISTRAR'S SIGNATURE: Curtis L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VE A15 (4)
15M 7/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01960

## CERTIFICATE OF DEATH

Reg. Dist. No. 01941

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Darlington

c. LENGTH OF STAY IN 1b: 35 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural- Darlington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Dublin

d. STREET ADDRESS: Dublin

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANITA Middle COOPER Last McKNIGHT

4. DATE OF DEATH: Month Feb. Day 19 Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 9, 1926

9. AGE (In years last birthday): 35 yrs

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Belair, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Don P. McKnight

14. MOTHER'S MAIDEN NAME: Zollie Tompkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Zollie T. McKnight, Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia - Viral — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/18, 1962, to 2/19, 1962, that I last saw the deceased alive on 2/19, 1962, and that death occurred at 2:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D. ADDRESS (Street, city or town, state): Darlington, Md. DATE SIGNED: 2/20/62

PHYSICIAN'S NAME (Type): Dudley Phillips MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 22, 1962

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Gardens

22d. LOCATION (City, town, or county) (State): Belair, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harkins ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: FEB 26 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01961 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01942

1. PLACE OF DEATH
a. COUNTY Harford — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace — c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Md — b. COUNTY Harford — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
d. STREET ADDRESS Box 332 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: David Middle: Lee Last: Messick
4. DATE OF DEATH Month: February Day: 3 Year: 1962

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: June 15 1942 — 9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10b. KIND OF BUSINESS OR INDUSTRY: Bata Shoe factory — 11. BIRTHPLACE (State or foreign country): Baltimore Md — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carrol P. Messick — 14. MOTHER'S MAIDEN NAME: Alice Hodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO: No — 17. INFORMANT: Carrol Messick — Address: Street Md. Box 332

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident

20c. TIME OF INJURY Hour: 3:45 a.m. — Month, Day, Year: 2-3 1962 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Fountain Green — 20f. (City or town): Bel Air — (County): Harford — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — Address (Street, city, town, or county): Bel Air Md — DATE SIGNED: 2-3-62

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb 6, 1962 — 22c. NAME OF CEMETERY OR CREMATORY: Conowingo — 22d. LOCATION (City, town, or country): Cecil Co — (State): Md

23. FUNERAL DIRECTOR: H & S Bailey — ADDRESS: Darlington, Md — 24a. REC'D BY REGISTRAR: DATE FEB 8 '62 — 24b. REGISTRAR'S SIGNATURE: Wilbur S. Thomas

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AISME 5-9 60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01962 01943

**1. PLACE OF DEATH**
a. COUNTY: Harford — Maryland
b. CITY OR TOWN (If outside corporate limits, write R.R.A. and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. State: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 723 Otsego
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Arthur — Middle: V. — Last: Mitchell

**4. DATE OF DEATH**: Month: 2/28/62 — Day — Year: 19

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 7/11/1877

**9. AGE** (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Penn. R.R.

**11. BIRTHPLACE** (County & State, or foreign country): Havre de Grace

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: George V. Mitchell

**14. MOTHER'S MAIDEN NAME**: Sarah Courtney

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: Unknown

**17. INFORMANT**: Emma C. Mitchell — Address: 723 Otsego Havre de Grace Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Insufficiency — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coryza — DUE TO
(c): Cerebral Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-1-..., 19 30 to 2/28..., 19 62, that (I) (we) last saw the deceased alive on 2/28/62 and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/3/62

23c. NAME OF CEMETERY OR CREMATORY: Grove

23d. LOCATION (City, town or county) (State): Aberdeen Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR — DATE: MAR 5 '62

25b. REGISTRAR'S SIGNATURE: [signature]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 [redacted] be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

**FOR STATE HEALTH DEPT.**

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01944

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air Rural
c. LENGTH OF STAY IN 1b: 6/30/1961
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford County Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma Middle: O. Last: Moody

4. DATE OF DEATH: Month: 2 Day: 9 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 31-1886

9. AGE (In years last Birthday): 75 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Oliver

14. MOTHER'S MAIDEN NAME: Louise Elsner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ralph Moody
Address: Aberdeen #1 - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma heart with Metastasis
170X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 2-9-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/12/62

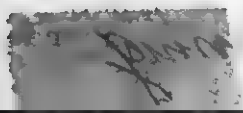
22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

22d. LOCATION (City, town, or country) (State): R.D. Bel Air, Maryland

23. FUNERAL DIRECTOR: John G. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: FEB 14 '62

24b. REGISTRAR'S SIGNATURE: L. Kraus



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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01964 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01945

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

1. **PLACE OF DEATH**
a. COUNTY Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN MARYLAND Dos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen
d. STREET ADDRESS RD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print) First: Joseph Middle: Lester Last: Nelson

4. **DATE OF DEATH** Month: February Day: 3 Year: 19 62

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25-1944

9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (Trainee)

10b. KIND OF BUSINESS OR INDUSTRY Bata Shoe Co.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lester Lee Nelson

14. MOTHER'S MAIDEN NAME Ada Annie Brooks Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 219-40-7182

17. INFORMANT Jane E. Hart Address Box 332 Aberdeen Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull
825X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture R femur compound

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident

20c. TIME OF INJURY Hour a.m. p.m. 3:35 Month, Day, Year 2-3 1962 While at work ☐ Not While at work ☐

20d. PLACE OF INJURY (Home, farm, factory, street, office b dg., etc.) Fountain Green

20e. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald Palmer M D

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

EXAMINER'S NAME (Type) Gerald C Palmer MD

DATE SIGNED 2-3-62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Feb 6th 1962

22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery

22d. LOCATION (City, town, or country) Bel Air, Rural (State) Maryland

23. FUNERAL DIRECTOR John G. Darring ADDRESS Aberdeen Maryland

24a. REC'D BY REGISTRAR DATE FEB 7 '62

24b. REGISTRAR'S SIGNATURE

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

01965 01946

**1. PLACE OF DEATH**
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
c. LENGTH OF STAY IN 1b: MARYLAND 12 FEB 62 - DEATH
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US ARMY HOSPITAL - APG, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CONOWINGO
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: ELIZABETH Middle: (NONE) Last: RATCLIFFE

**4. DATE OF DEATH**: Month: FEB Day: 18 Year: 1962

**5. SEX**: FEMALE

**6. COLOR OR RACE**: WHITE

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 18 APR 1913

**9. AGE** (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**: NONE

**11. BIRTHPLACE** (County & State, or foreign country): ROWLANDSVILLE, Md. USA

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME**: SAMUEL MACAULEY

**14. MOTHER'S MAIDEN NAME**: BERTHA OTTEL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): NO

**16. SOCIAL SECURITY NO.**: 219-07-3262

**17. INFORMANT**: J. RATCLIFFE-HUSB-RISING SUN, Md. 36F5 Address PH. #

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): metastatic cancer
171X
DUE TO (b): adenocarcinoma of cervix
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 2-11 19 62 to 2-18 19 62, that ☐ (we) last saw the deceased alive on 2-18 19 62 and that death occured at 1:55 P.M. from the causes and on the date stated above

22a. SIGNATURE: Thomas J Fraberm M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/21/1962

23c. NAME OF CEMETERY ~~OR CREMATORY~~: Mt. Pleasant

23d. LOCATION (City, town or county): Colora (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Ralph M Reed, Rising Sun, Md ADDRESS

25a. REC'D BY REGISTRAR DATE FEB 21 '62

25b. REGISTRAR'S SIGNATURE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

01966 Item 9 Form G508 - 3/1/62 - iwk 01947

1. **PLACE OF DEATH**
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 16 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
d. STREET ADDRESS R.F.D. Box 20C
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Baby Girl — Middle — Last Standiford
4. DATE OF DEATH: Month 2 — Day 22 — Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-21-62
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours 17 Min. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Standiford
14. MOTHER'S MAIDEN NAME: Virginia Zentrick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John Standiford Address: Edgewood Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 754, E — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Subarachnoid Hemorrhage — DUE TO
(c): Congenital Heart Disease — Atelectasis & Pneumonia.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Maternal Eclampsia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/21, 1962 to 2/22, 1962, that (I) (we) last saw the deceased alive on 2/22 1962, and that death occured at 3:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE F. J. Hatem
22b. DATE SIGNED 2/23/62
22c. PHYSICIAN'S NAME (Type) F.J. Hatem
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS 607 E. Union Ave., Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL
23b. DATE THEREOF Feb. 24, 1962
23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial
23d. Abingdon, Harford, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas
ADDRESS Howard K. McComas & Son Abingdon Maryland.

25a. REC'D BY REGISTRAR DATE FEB 27 '62
25b. REGISTRAR'S SIGNATURE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01967 01948

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 28 Aberdeen
d. STREET ADDRESS: 45 Monroe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Otis; Middle: ; Last: Thompson

4. DATE OF DEATH: Month: February; Day: 1; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-12-1901

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Contractor

11. BIRTHPLACE (County & State, or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 220-01-8635

17. INFORMANT: Address: Hospital Record.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Diabetes Mellitus with Mild Acidosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertensive Cardio Renal disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/29, 1962 to 2/1, 1962 that (I) (we) last saw the deceased alive on 2/1, 1962, and that death occured at 6:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/2/62

22c. PHYSICIAN'S NAME (Type): George T. Stansbury

22d. ADDRESS: 569 Revolution St. Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-8-62

23c. NAME OF CEMETERY OR CREMATORY: Union Methodist

23d. LOCATION (City, town or county) (State): Aberdeen, Hayford Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Otelia J. Bullock - Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Timms

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

01968 — 01949

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 502 Rock Spring Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: W. Last: Wagg

4. DATE OF DEATH: Month: Feb Day: 18 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 1, 1885

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR, Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Home Construction

11. BIRTHPLACE (County & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Wagg

14. MOTHER'S MAIDEN NAME: Louise Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-03-2957

17. INFORMANT: J. Alma Wagg Address: 502 Rock Spring Ave., Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO (b): Arteriosclerotic, Cardiovascular Disease — 3-4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (1) Pneumonia, right lower lobe (2) Senility (3) Malnutrition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not White at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 8th, 1962 to Feb. 18th, 1962 that (I) (we) last saw the deceased alive on Feb. 18th, 1962 and that death occured at 8:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loc, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/18/62

22c. PHYSICIAN'S NAME (Type): Edward C. Loc, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 21, 1962

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion ADDRESS

23d. LOCATION (City, town or county) (State): Bel Air, Harford, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Mc Comas & Son

Howard K. Mc Comas & Son Abingdon, Maryland.

25a. REC'D BY REGISTRAR DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Carlton S. Hines

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

01969 — 01950

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Prov. Ground
   c. LENGTH OF STAY IN 1b: 13 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US Army Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: HARFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
   d. STREET ADDRESS: #1 Rigdon Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: M. — Last: WALSH

4. DATE OF DEATH: Month: February — Day: 27 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/25/1893 — Aberdeen

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Maid~~ Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ~~None~~ Home

11. BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? USA Naturalized

13. FATHER'S NAME: John Dooner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Thomas Walsh Jr (Son) — Address: #1 Rigdon Rd. Aberdeen, Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bronchopneumonia | 2 weeks |
| DUE TO (b) | Congestive Heart Failure | 2 weeks |
| DUE TO (c) | Hypertensive and Arteriosclerotic Heart Disease | Several years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that I (this hospital) attended the deceased from February 14, 1962, to February 27 19.62 that (I) (we) last saw the deceased alive on February 27 19.62, and that death occured at 9:20PM from the causes and on the date stated above.

22a. SIGNATURE: Albert Frankel — M D

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: February 27, 1962

22c. PHYSICIAN'S NAME (Type): ALBERT FRANKEL, Captain, MC

22d. ADDRESS: US Army Hospital, Aberdeen Prov Gd. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/3/1962

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens - Bel Air Maryland

23d. LOCATION (City, town or county) (State):

24. FUNERAL DIRECTOR'S SIGNATURE: Tarring Funeral Home - Aberdeen Md — ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAR 5 '62

25b. REGISTRAR'S SIGNATURE: T. E. Tome

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01970 01951

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b: 1 hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace Md.
d. STREET ADDRESS: 301 So. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward — Middle — Last Watts

4. DATE OF DEATH: Month Feb. — Day 5 — Year 1962

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/11/1890

9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: RR Mail Clerk

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore Watts

14. MOTHER'S MAIDEN NAME: Mary Busher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Margaret H. Watts — Address: 305 S. Union Ave, Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 11 years.
DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary arteriosclerosis + Chronic bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 1st., 1961 to Feb. 5th., 1962 that (I) (~~we~~) last saw the deceased alive on Feb. 5th, 1962, and that death occured at 10:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/5/62

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/7/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Erin

23d. LOCATION (City, town or county) (State): Havre de Grace Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington Son, Havre de Grace, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE FEB 7 '62

25b. REGISTRAR'S SIGNATURE: Cathryn L. Tennyson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01952

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon Rural
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Abingdon Rural
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Blanche — Middle M. — Last Wehry

4. DATE OF DEATH: Month February — Day 6 — Year 1962

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 7-24-12 — 9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Penna., — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Isaiah Like — 14. MOTHER'S MAIDEN NAME: Hazel Shrubb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT: Thomas C. Whery — Address: Abingdon Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☐ — DATE SIGNED: 2-6-62

EXAMINER'S NAME (Type): Gerald C Palmer M.D. — Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb. 8, 1962 — 22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens — 22d. LOCATION (City, town, or country) (State): Bel Air, Harford, Maryland.

23. FUNERAL DIRECTOR: Howard K. Mc Comas & Son — ADDRESS: Abingdon Maryland — 24a. REC'D BY REGISTRAR DATE: FEB 9 '62 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60